UNC GILLINGS SCHOOL OF GLOBAL PUBLIC HEALTH

THE NORTH CAROLINA Institute *for* Public Health

Executive Summary

Legal Frameworks Supporting Public Health Department Accreditation:

Key Findings and Lessons Learned from Ten States

June 2011

This research was carried out by the North Carolina Institute for Public Health at the University of North Carolina Gillings School of Global Public Health. This research was funded by the Robert Wood Johnson Foundation's Public Health Law Research program. The contents are solely the responsibility of the authors and do not necessarily represent the official views of the UNC Gillings School of Public Health or the Robert Wood Johnson Foundation.

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> "Accreditation is a major accomplishment for a health department. It means that it is addressing key community health problems. Just as the public expects hospitals, law enforcement agencies and schools to be accredited, so should they come to expect health departments." –CDC Director Thomas R. Frieden

Introduction

The accreditation of public health departments is expected to play a significant role in strengthening the performance, effectiveness, and accountability of the nation's public health system. After extensive study, a national voluntary accreditation program has been endorsed by leading public health organizations, including the American Public Health Association (APHA), Association of State and Territorial Health Officials (ASTHO), National Association of County and City Health Officials (NACCHO), and the National Association of Local Boards of Health (NALBOH).

The Public Health Accreditation Board (PHAB) was incorporated in 2007. With support from the Robert Wood Johnson Foundation and the Centers for Disease Control and Prevention (CDC), PHAB has been working with public health experts to develop a national voluntary accreditation program for state and local public health departments. In 2009 – 2010, 30 state, local, and tribal health departments ("beta test sites") piloted the full accreditation process and provided feedback to PHAB. The program is now set to launch in fall 2011. PHAB's goal is to have 60% of the US population served by an accredited public health department by 2015.

In 2010-2011, the North Carolina Institute for Public Health conducted a study of state legal frameworks supporting public health department accreditation or related programs (e.g., certification, performance management, quality improvement). First, a mapping study of 23 states was conducted to identify current programs and their legal frameworks (see Table 1). Ten states were then selected for in-depth study. These states are Illinois, Iowa, Kansas, Michigan, Missouri, Montana, New Hampshire, North Carolina, Oklahoma, and Wisconsin. While all ten states are planning to participate in the national program, they approach accreditation from a variety of starting points. Some have mandatory accreditation programs based in statute, while others operate voluntary performance management or quality improvement programs. Still others are experimenting with regional cooperation (through interlocal agreements) as an approach to accreditation and/or quality improvement.

This report presents the results of the study, with the hope that the research findings and legal lessons learned from these ten diverse states will be of benefit to other states as they prepare to participate in the national voluntary accreditation program.

Methods

Data was collected in two phases. In the first phase, the research team conducted semi-structured interviews with public health practitioners in 23 states to identify the type of program currently in existence in the state (accreditation, certification, performance management, quality improvement, other) and the legal framework supporting it. In the second phase of data collection, ten states were selected from among the original 23 to participate in case studies. Semi-structured interviews were conducted with public health practitioners and other stakeholders involved with accreditation or related programs in each case study state (2 – 6 interviews per state). Interviewees included current and former state and local public health officials (including state public health attorneys), as well as representatives of state public health institutes, associations of counties, associations of local health departments, associations of public health officials, and private legal consultants.

Relevant legal and policy documents were collected from each state, as well as educational materials and formal and informal program-related documents, such as program descriptions, guides, and fact sheets. For each state, a case record was created which included transcribed interviews and related documents. Case records were analyzed to identify unique and cross-cutting themes related to legal issues and lessons learned regarding the development of state-based accreditation and related programs. In addition, case records were analyzed to identify legal issues related to participation in the national voluntary accreditation program.

Key Findings

This section presents the key findings of the study. First, the legal frameworks supporting current state-based accreditation and related programs in the ten case study states are summarized. Second, the impact of the national voluntary accreditation program on these legal frameworks is examined. Third, findings related to shared service delivery as an approach to accreditation are summarized. Finally, suggestions from case study states as to how the federal government might incentivize participation in the national accreditation program (through the legal terms and conditions of various funding mechanisms) are discussed.

I. Legal Framework of Current State-Based Accreditation and Related Programs

- As illustrated in Table 1, the ten case study states are approaching the national accreditation program from a variety of starting points:
    - Iowa, Michigan, Missouri and North Carolina have state accreditation programs; two of which are mandatory for LHDs. Of these four programs, three are based in statute, while one is operated by a nonprofit organization independent of state laws, regulations, or policies.

- Illinois has a voluntary certification program based in statute and regulation; however, certification is an eligibility requirement for state local health grants.

- Wisconsin has a regulatory "review process" which operates similarly to certification. The process is mandatory for LHDs and based in statute and regulation.

- The four remaining case study states are engaged in quality improvement processes. Kansas is examining shared service delivery (often based in interlocal agreements) as a way to improve quality through regional cooperation. Montana is implementing national standards through a legislatively-enacted pilot project. New Hampshire is monitoring the implementation of a public health improvement action plan through a special council created by the state legislature. Oklahoma is administering a mandatory performance management system through state health department policy.

- Public health agency attorneys and private attorneys (consultants) were involved in creating the legal frameworks for these programs in six of the ten case study states.

II. Impact of National Accreditation Program on Current Legal Framework

- All ten case study states are planning to participate in the national voluntary accreditation program, although to varying degrees.

- Because the national program is voluntary, no states anticipate significant barriers in their laws, regulations, or policies that will prohibit or hinder participation. Minor conforming amendments or technical changes may be needed in some states.

- At least five of the six states with accreditation or certification programs (Illinois, Iowa, Michigan, North Carolina, and Wisconsin) plan to maintain their state program after the national voluntary accreditation program is launched. Their plans at the time of this study are indicated below.

    - Iowa and North Carolina may seek to have their state program "deemed equivalent" to the national voluntary accreditation program by PHAB. In this case, no changes to state laws, regulations, or policy are anticipated.

    - Illinois and Wisconsin are considering the reverse – the state health department would recognize a LHD that is accredited by PHAB as having met the requirements of their state program. In these states, some conforming modifications to relevant state laws, regulations, or policy may be needed in order to acknowledge accreditation by PHAB as satisfying state requirements. However, these states noted that no modifications can be made until the national program is officially launched.

- Michigan plans to run their mandatory accreditation program alongside the national voluntary program. LHDs in this state would be required to participate in the state program, and could, if desired, also seek accreditation by PHAB.

- Missouri, whose program is run by a nonprofit agency independent of state law, regulation, or policy, is grappling with the question of whether or not it makes sense to run a voluntary state program alongside a voluntary national program.

- The remaining four case study states (Kansas, Montana, New Hampshire, and Oklahoma) are *not* planning to create new state-based accreditation or certification programs.

III. Shared Service Delivery as an Approach to Accreditation

- Shared service delivery among two or more local health departments (LHDs) is one approach to accreditation for LHDs that cannot meet all standards on their own. There is a wide spectrum of options for shared service delivery ranging from informal agreements to consolidation of health departments into a district.

  - In some states, shared service delivery is viewed neutrally or positively by LHDs. In Kansas, shared service delivery arrangements fall in the middle of the spectrum and generally involve interlocal agreements where LHDs retain their autonomy.

  - In other states, many LHDs fear that shared service delivery will lead to consolidation (i.e., merging of LHDs into a district or regional health department) and loss of local autonomy and resources.

IV. Funding Accreditation

- Many interviewees reported concerns about how state and local health departments will meet costs associated with PHAB fees and accreditation preparation activities (e.g., carrying out a community health assessment, developing a community health improvement plan, gathering documentation).

- Case study states indicated they had few resources to assist LHDs with accreditation costs. While technical assistance could be provided by most states, only two states indicated funds were available to assist LHDs with preparation activities.

- Several interviewees indicated that they believed accreditation might eventually become an eligibility requirement for federal funding.

- To assist state and local agencies with these costs, several suggestions related to the legal terms and conditions of federal assistance mechanisms were made by interviewees:

- With regard to assisting state and local agencies with the cost of accreditation, the federal government could:

  - ✓ create a special grant program for accreditation
  - ✓ designate a percentage of categorical grants specifically for accreditation-related activities
  - ✓ target health care reform funds to accreditation preparation activities
  - ✓ make PHAB fees an allowable administrative cost under categorical grants

- The federal government could offer incentives to accredited agencies in the funding application process for categorical grants by:

  - ✓ adding scoring points to competitive grant applications based upon percentage of LHDs accredited in the state
  - ✓ expediting applications from accredited agencies
  - ✓ accepting accredited status as satisfying eligibility requirements

- Create quality improvement staff positions in state and local health departments using Affordable Care Act funding.

- Make federal funding more flexible to support local plans and priorities determined through community health assessments and improvement plans (which are PHAB prerequisites).

- Avoid federal financial disincentives or penalties; instead, use positive reinforcement.

Discussion: Legal and Policy Lessons Learned

This section presents the legal and policy lessons learned from the ten case study states with regard to 1) developing state accreditation or related programs; 2) preparing for the national accreditation program; and 3) shared service delivery as an approach to accreditation.

I. Developing State Accreditation or Related Programs

- **"There's no way we could have moved forward…if the locals weren't on board**." Creation of state accreditation and related programs and the adoption of related laws, regulations and/or policies involved extensive collaboration between state and local health practitioners. Interviewees stressed that the development of these programs required close collaboration among state and local health practitioners.

- **"Building awareness [of elected officials] is a never ending process."** Some states developed extensive educational materials to educate legislators *first* on the role of public health and *second* on how accreditation would benefit citizens. Interviewees in these states felt intensive education was the key to winning the support of legislators and other stakeholders. Given the high degree of turnover among local and state elected officials, as well as among other stakeholders, education and awareness-raising must be viewed as on-going process.

- **"Technical assistance was really about reducing the level of fear, making [LHDs] understand that we were with them…we were going to help them succeed in this."** In some states, extensive technical assistance programs were provided by the state health department (or a partner agency) to assist LHDs in developing the capacity and skills to meet accreditation/certification requirements (e.g., how to conduct a community health assessment and develop a corresponding community health improvement plan). Interviewees felt that these technical assistance programs helped reduce LHD fears around accreditation and related programs and the passage of related laws and regulations.

- **"It's not about how big you are, it's how good you are."** In one state, accreditation was a way to shift the focus of legal/policy discussions away from consolidation (or "districting") of small health departments. Improving the overall quality of a local health system is not about reducing the number of health departments, but about ensuring that all health departments, regardless of size, are providing a basic set of defined services.

- **"We needed the effect of the law."** In states that opted to pass statutes to create their programs, interviewees reported that stakeholders want to formalize and/or institutionalize programs so they would have more weight and a far-reaching effect.

- **"We had pilot counties…to prove to our county commissioners and to our legislators that this could work…so when our law passed, we had those pilot standards so we didn't have to reinvent the wheel."** In two states where laws establishing accreditation were recently passed, interviewees reported that piloting accreditation standards allowed for valuable lessons to be learned, and demonstrated proof of concept to legislators and other elected officials, thereby garnering support for passage of legislation. In addition, once laws were passed, rule-making related to standards was not an onerous process as pilot standards only needed to be modified to incorporate lessons learned.

II. Preparing for the National Voluntary Accreditation Program

- **"Lead by example."** Some state health departments have made the determination that to effectively encourage local participation in the national program, they must lead by example. Interviewees in these states indicated the state health department plans to be "first in line" to apply for accreditation when the national program is launched later this year.

- **"Don't lose information."** In states that are considering modifying their laws, regulations, or policies to recognize accreditation by PHAB as meeting the requirements of state programs, interviewees indicated that any modifications would require that community health assessments and plans be submitted to the state for record-keeping, but not review, purposes. In this way, the state can continue to track necessary data and monitor the priorities that LHDs are setting for themselves.

III. Shared Service Delivery as an Approach to Accreditation

- **"It's the region that enables the counties to do what they need to do, not the other way around."** Interviewees reported that the key to local support for shared service delivery is empowering locals to determine their own partners and arrangements. There are many models for shared service delivery that do not entail consolidation of health departments. "We've found what works best is when the locals group themselves according to their relationship and need...When it works best it is when it's their idea rather than it is forced upon them."

- **"If you are a home rule state, don't pretend that a need to share services doesn't exist. As we look at accreditation…it's the elephant in the room."** Some interviewees in decentralized states expressed concern that state and local health departments were vulnerable to reorganization (e.g., merging of health departments or consolidation of health departments into umbrella human service organizations) that might reduce their autonomy and visibility. Shared service delivery (based in interlocal agreements and limited to specific services) was viewed as a way of maintaining, rather than losing, autonomy. "I think health department directors are…more open now than they've ever been, at least the leaders, the ones on the cutting edge...are much more receptive to sharing of services as a potential solution for a range of problems."

- **"Have a meeting of the minds on the rules of the game."** Effective regional cooperation for shared service delivery involves carefully laying out ground rules and devising a governance structure. In many states, interlocal agreement acts require that participating agencies spell out, for example, the duration and purpose of the agreement, manner of financing and of establishing and maintaining a budget, and methods for terminating the agreement.

Additional Resources

Articles and Reports

Beitsch LM, Landrum LB, Chang C, Wojciehowski K. Public Health Laws and Implications for a National Accreditation Program: Parallel Roadways Without Intersection? *Journal of Public Health Management and Practice*, July/August 2007, 13(4): 383-387.

Davis MV, Cannon MM, Corso L, Lenaway D, Baker EL. Incentives to Encourage Participation in the National Public Health Accreditation Model: A Systematic Investigation. *American Journal of Public Health*, September 2009, 99(9): 1705-1711.

Libbey P and Miahara B. Cross-Jurisdictional Relationships in Local Public Health: Preliminary Results of an Environmental Scan, January 2011. Available at: http://www.rwjf.org/files/research/20110201libbeyfinal.pdf

Matthews GW and Baker EL. Looking Back from the Future: Connecting Accreditation, Health Reform, and Political Opportunities. *Journal of Public Health Management and Practice*, 2010, 16(4): 367-369.

Laws and Regulations

Citations for relevant laws and regulations for the mapping and case study states are included in Tables 1 and 2.

Websites

The Network for Public Health Law. Public Health Agency and Shared Service Delivery. http://www.publichealthlawnetwork.org/about-the-network/public-health-agency-accreditation-and-shared-service-delivery/

NACCHO: Accreditation Preparation and Quality Improvement. http://www.naccho.org/topics/infrastructure/accreditation/

NACCHO: Regionalization. http://www.naccho.org/topics/infrastructure/regionalization/index.cfm

Public Health Accreditation Board. http://www.phaboard.org/

Conclusion

The key findings and legal lessons learned from the ten case studies presented in this report are intended to be of use to other states as they examine their existing state public health statutes, regulations, and policies in preparation for the national accreditation program. Motivating many states, in part, is the belief that accreditation might one day be tied to eligibility for federal and other funding. However, interviewees also stressed the value of the accreditation process itself – from developing critical assessment and planning skills among public health practitioners, to improving the efficiency, accountability, and sustainability of public health systems, to gaining recognition from elected officials which can translate into additional resources.

> "Now they have a great community health assessment that really reflects their county…I think there [is] intrinsic value to the system to have some of these smaller health departments learning how to do this."
> -State public health official

> "We're working towards accreditation, but for me that is not the goal, it's kind of a side benefit. The goal is to operate more efficiently."
> -Local public health administrator

> "We've seen some agencies that got recognition [for being accredited] from their local government structure that meant more money for them, or better access to the mayor's office."
> -Director of a nonprofit public health institute

Table 1: Case Study States

State	Organization of Public Health System*	Current State Program	Legal Framework	Approach to PHAB Accreditation	Legal Strategies for Achieving PHAB Accreditation
IL	Illinois Department of Public Health (IDPH) has a shared/mixed relationship with the state's 95 LHDs	Illinois Local Health Department Certification Program (launched 1993)	• Certification is based in statute: 55 ILCS 5 authorizes IDPH to establish minimum standards; specific regulations are found in Illinois Administrative Code Title 77, Section 600 • Certification is awarded by IDPH • LHD participation in the certification program is voluntary, but certification is an eligibility requirement for Local Health Protection Grants awarded by IDPH	• Recommendation for LHDs to participate in PHAB accreditation as an alternative to IL certification • Decided against developing state accreditation program	• Considering a mechanism under the existing regulatory framework to recognize accreditation by PHAB as satisfying Illinois certification requirements
IA	Iowa Department of Public Health (IDPH) has a decentralized relationship with the state's 101 city, county and regional LHDs	Iowa Voluntary Accreditation Program (established 2009 with launch date of 2012)	• Accreditation is specifically authorized by statute: Ch. 135A: Public Health Modernization Act of 2009 • IDPH will administer the program with the accrediting body to be determined by the Public Health Advisory Council • LHD participation is voluntary	• IDPH plans to apply for accreditation	• New statute permitting district health departments • IDPH plans to seek equivalency with PHAB accreditation
KS	The Division of Health of the Kansas Department of Health and Environment (KDHE), has a decentralized relationship with the state's 100 single and multi-county LHDs	Regional cooperation and quality improvement efforts are currently underway in Kansas	• Quality improvement is by KDHE policy • Quality improvement projects are being led by the Kansas Health Institute, Kansas Association of Local Health Departments, and the Kansas Department of Health and Environment • LHD participation is voluntary	• Studying regional accreditation	• Regional cooperation via interlocal agreements under KSA 12-2901 et seq.

State	Organization of Public Health System*	Current Program	Legal Framework	Approach to PHAB Accreditation	Legal Strategies for Achieving PHAB Accreditation
MI	Michigan Department of Community Health (MDCH) has a decentralized relationship with the state's 45 city, single county, and multi-county LHDs	Michigan Local Public Health Accreditation Program (established 1996; launched 1999)	• Accreditation is based in statute: MCL 333.24729 directs MDCH to establish minimum standards (Act 368 of 1978, Public Health Code); MDCH policy (Policy 8000) outlines the principles governing the development and adoption of minimum program requirements • MDCH is the accrediting body with daily operations handled by the Michigan Public Health Institute • LHD participation is mandatory	• No plans to seek equivalency from PHAB • Will maintain existing state accreditation program after PHAB launch	• Legal/policy environment allows LHDs to apply for national accreditation if they desire
MO	The Division of Community and Public Health of the Missouri Department of Health and Senior Services (MDHSS), has a decentralized relationship with the state's 115 LHDs	Missouri Voluntary Local Public Health Agency Accreditation Program (launched 2003)	• The accreditation program operates independent of state laws, regulations, and policies • The Missouri Institute for Community Health (MICH), a nonprofit agency, is the accrediting body • LHD participation in voluntary	• Decision pending whether to continue state program • MDHSS & some LHDs plan to apply for accreditation	• Legal/policy environment allows LHDs to apply for national accreditation if they desire
MT	The Montana Department of Public Health and Human Resources (MDPHHS) has a decentralized relationship with the state's 52 LHDs	Pilot Project for Implementing National Public Health Standards (launched 2009)	• The pilot project is by statute (HB 173) (2009) • MDPHHS is administering the project • LHD participation is voluntary	• MDPHHS & some LHDs plan to apply for PHAB accreditation	• Legal/policy environment allows LHDs to apply for accreditation if they desire
NH	The Division of Public Health Services (DPHS) of the New Hampshire Department of Health and Human Services has a decentralized relationship with the state's 2 LHDs	New Hampshire Public Health Improvement Action Plan (released 2008)	• The plan was developed by the Public Health Improvement Services Council which is responsible for monitoring its implementation • The Public Health Improvement Services Council is a legislatively enacted body (HB 491) (2007)	• DPHS and 2 LHDs plan to apply for PHAB accreditation	• Uncertain legal status of Regional Public Health Networks for PHAB accreditation

State	Organization of Public Health System*	Current State Program	Legal Framework	Approach to PHAB Accreditation	Legal Strategies for Achieving PHAB Accreditation
NC	The Division of Public Health (DPH) of the North Carolina Department of Health and Human Services has a decentralized relationship with the state's 85 single county and multi-county LHDs	North Carolina Local Health Department Accreditation Program (established 2005; launched 2006)	• Accreditation is specifically authorized by statute: NCGS 130A-34.1 (2005); regulations were developed in 2006 (10A NCAC 48A) • An independent Accreditation Board is established by 130A-34.1; the NC Institute for Public Health at the UNC Gillings School of Global Public Health administers the accreditation program • LHD participation is mandatory	• DPH plans to apply for accreditation	• DPH plans to seek equivalency with PHAB accreditation
OK	Oklahoma State Department of Health (OSDH) has a shared/mixed relationship with the state's 68 centralized LHDs and 2 independent city-county LHDs	Step UP Performance Management System (launched 2008)	• Performance management is by state health department policy • Step UP is administered by OSDH • LHD participation is mandatory	• OSDH & independent city-county LHDs plan to apply for PHAB accreditation, with other LHDs to follow	• Legal/policy environment allows LHDs to apply for national accreditation if they desire
WI	The Division of Public Health (DPH) of the Wisconsin Department of Health Services (WDHS) has a shared/mixed relationship with the state's 92 county and municipal LHDs	Wisconsin Local Health Department Review Process (launched 1998)	• The Review Process is based is statute: Chapter 251.20 (1993) directs WDHS to specify required services; specific regulations are found in administrative code: Chapter DHS 140 (1998) • The Review Process is administered by DPH; LHD level is awarded by the state health director • LHD participation is mandatory (there are 3 levels of LHDs, all LHDs must achieve a minimum of Level I)	• State health plan calls for all LHDs to be accredited using national standards by 2020	• Planned revisions to DHS 140 to incorporate some PHAB standards • May recognize LHDs accredited by PHAB as meeting Review requirements

*Association of State and Territorial Health Officials (ASTHO). *Profile of State Public Health: Volume One*. Available at: http://www.astho.org/Display/AssetDisplay.aspx?id=4078. Definitions: *Centralized* = State health agency provides local services; *Decentralized* = Local health departments are organizationally independent of the state health agency; *Shared/mixed* = Combination of centralized and decentralized.